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Non-Labor A number of different proxies are used to measure price movements in non-labor expenses incurred by hospitals. In calculating the initial trend factors, an estimate of the non-labor component is made based upon the projection of the GNP Implicit Price Deflator. The final trend factor calculations are made using the actual changes in the non-labor proxies.

Groupings As of the 1988 rate period, for purposes of trend factor calculations, the definition of a teaching hospital was modified to eliminate the requirement that the facility must have one approved residency program in surgery and one in internal medicine or family practice. The current definition requires only that the facility have a minimum of five approved residency programs.

(h) For rate periods on and after April 1, 2000, the commissioner shall establish trend factors for rates of payment for hospitals to project for the effects of inflation. The factors shall be applied to the appropriate portion of reimbursable costs calculated pursuant to section 86-1.54 of this Subpart.

(1) In developing trend factors for such rates of payment, the commissioner shall use the most recent Congressional Budget Office estimate of the rate year's U.S. Consumer Price Index for all urban consumers published in the Congressional Budget Office Economic and Budget Outlook after June first of the rate year prior to the year for which rates are being developed.

(2) After the final U.S. Consumer Price Index (CPI) for all urban consumers is published by the United States Department of Labor, Bureau of Labor Statistics, for a particular rate year, the commissioner shall reconcile such final CPI to the projection used in paragraph (1) of this subdivision and any difference will be included in the prospective trend factor for the current year.

(3) At the time adjustments are made to the trend factors in accordance with this subdivision, adjustments shall be made to all inpatient rates of payment affected by the trend factor adjustment.

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Supersedes TN 94-06 Effective Date JAN 01 2000

86-1.59 Capital expense reimbursement for DRG case based rates of payment. Capital expense shall not include capital expense allocated to exempt units and designated AIDS centers.

(a) The allowable costs of fixed capital (including but not limited to depreciation, rentals and interest on capital debt or, for hospitals financed pursuant to Article 28-B of the Public Health Law, amortization in lieu of depreciation, and interest and other approved expenses associated with both fixed capital and major movable equipment) and major movable equipment shall, with the exception noted in subdivisions (c), (g), (h), (i) and (j) of this section, be reimbursed based on budgeted data and shall be reconciled to total actual expense for the rate year and shall be determined and computed in accordance with the provisions of sections 86-1.23, 86-1.24, 86-1.29, 86-1.30 and 86-1.32 of this Subpart. In order for budgeted expenses to be reconciled to actual:

(1) Rates of payment for a general hospital shall be adjusted to reflect the dollar difference between budgeted capital related inpatient expenses included in the computation of rates of payment for a prior rate period and actual capital related inpatient expenses for the same prior rate period. For rates commencing April 1, 1995 through March 31, 1999 and July 1, 1999 through March 31, [2000] 2001, if a factor for the reconciliation of budgeted to actual capital related inpatient expenses for a prior year is included in the capital related inpatient expenses component of rates of payment, such component shall be reduced by the difference between the applicable reconciled capital related inpatient expenses for such prior year, and capital related inpatient expenses for such prior year calculated based on a determination of costs related to services provided to beneficiaries of the Title XVIII federal social security act (Medicare) based on the hospital's average capital related inpatient expenses computed on a per diem basis.

(2) This amount shall be adjusted to reflect increases or decreases in volume for the same rate period.

(3) Capital related inpatient expenses included in the computation of payment rates based on budget shall not be included in the computation of

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transferred out patient days and which shall be reconciled to actual rate year days) and the non-exempt hospital's average budgeted capital cost per day calculated using total non-exempt budgeted days. Budgeted capital costs shall be reconciled to actual capital costs for the non-exempt hospital in the rate year after these data are available based upon the non-Medicare share of capital costs derived by subtracting Medicare capital costs from total capital costs. Medicare capital costs shall be determined based upon the hospital's average capital related inpatient per diem effective through March 31, 1999 and from July 1, 1999 through March 31, [2000] 2003. Total Medicare capital shall be these ancillary costs added to the routine portion of Medicare inpatient capital, adjusted for secondary payors.

(3) Allocation to payments for transfer patients and short-stay patient. Budgeted capital costs shall be allocated to payments for transferred patients and short-stay patients based on estimated non-exempt unit non-Medicare days reconciled to actual rate year days.

(f) Payment for budgeted allocated capital costs.

(1) Capital per diems for exempt units and hospitals shall be calculated by dividing the allocated non-Medicare capital costs identified in paragraph (e)(1) of this section by the 1985 exempt unit days, reconciled to rate year days and actual rate year exempt unit or hospital approved capital expense.

(2) Capital payments for DRG case-based rates shall be determined by dividing the budgeted capital allocated to such rates by the hospital's most recently available annual non-Medicare, non-exempt unit discharges.

TN 00-06 Approval Date JUN 06 2001  
Supersedes TN 97-26 Effective Date JAN 01 2000

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and actual rate year non-exempt unit or hospital-approved capital expense.

(3) Capital payments for transferred and short stay patients shall be the non-exempt hospital's average budgeted capital cost per day determined pursuant to paragraphs (2) and (3) of subdivision (e) of this section.

(g) Effective April 1, 1995 through March 31, 1999 and July 1, 1999 through March 31, [2000] 2003, the capital related inpatient expense component of the rate shall be based on the budgeted capital related expense applicable to the rate year decreased to reflect the percentage amount by which the budget for the applicable base year's capital related inpatient expense exceeded actual expense.

(h) Effective April 1, 1995 through March 31, 1999 and July 1, 1999 through March 31 [2000] 2003, rates of payment for inpatient acute care services associated with the capital related expense component and the capital cost per visit components shall be adjusted to exclude such expenses related to the following:

- (i) 44% of major moveable equipment
- (ii) staff housing.

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Supersedes TN 97-26 Effective Date JAN 01 2000

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to the final determinations on all facility appeals statewide submitted in accordance with this subparagraph.

(iii) The case mix adjustment percentage determined pursuant to this paragraph shall be prospectively applied and subsequently reconciled upon the conclusion of the appeal process as identified in subparagraph (ii) of this subparagraph.

(iv) For the rate years commencing January 1, 1997 through September 30, 1999, the maximum allowable increase in the Medicaid statewide average reported case mix in an historical rate year shall not exceed, on a cumulative basis, one percent from the 1996 Medicaid statewide average reported case mix for the 1997 rate year and an additional one per cent per year from the 1996 Medicaid statewide average reported case mix. Effective for the period October 1, 1999 through [December 31, 2000,] March 31, 2003, the maximum allowable increase in the Medicaid statewide average reported case mix shall not exceed four percent for the period October 1, 1999 through December 31, 2000 plus an additional one percent per year thereafter. The methodology used to adjust rates of payment for the periods commencing January 1, 1997 and thereafter shall be the same as that described in subparagraphs (i) – (iii) of this paragraph, however, the data used to determine any and all case mix indexes shall be based on discharges for only those patients that are eligible for medical assistance pursuant to title eleven of article five of the social services law, including such patients enrolled in health maintenance organizations. In addition, the 1996 adjustment determined pursuant to subparagraphs (i) – (iii) of this paragraph shall be added to the adjustments determined in this subparagraph.

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(1) For rate years commencing January 1, 1991 and prior to January 1, 1997, each eligible major public general hospital shall receive a portion of its bad debt and charity care need equal to 110 percent of the result of the application of the percentage of statewide inpatient reimbursable costs excluding costs related to services provided to beneficiaries of Medicare, developed on the basis of 1985 financial and statistical reports, to the statewide resources for the rate year. For rate periods commencing January 1, 1997 [and thereafter] through December 31, 2002, each eligible major public general hospital shall receive an amount equal to the amount allocated to such major public hospital for the period January 1, 1996 through December 31, 1996. For the period January 1, 2003 through June 30, 2003, each eligible major public general hospital shall receive an amount equal to one-half the amount allocated to such major public hospital for the period January 1, 1996 through December 31, 1996.

(2) For rate periods prior to January 1, 1997, the balance of the statewide resources after the Medicaid disproportionate share payments are made in accordance with paragraph (1) of this subdivision shall be distributed to voluntary sector hospitals on the basis of each hospital's targeted need share. For rate periods commencing January 1, 1997 and thereafter, the balance of unallocated funds after the Medicaid disproportionate share payments are made in accordance with paragraph (1) of this subdivision and funds are reserved for distribution as high need adjustments in accordance with subdivision (h) of this section and shall be distributed to eligible hospitals, excluding major public general hospitals, on the basis of targeted need share adjusted for transition factors pursuant to subdivision (i) of this section.

(i) Need calculations shall be based on need data for the year 2 years prior to the rate year.

(ii) For the rate periods commencing January 1, 1991 and prior to January 1, 1997, the scale specified in subparagraph (iii) of this paragraph and for rate periods commencing January 1, 1997 and thereafter, the scale specified in subparagraph (iv) shall be utilized to calculate individual hospital's nominal payment amounts on the basis of the percentage relationship between their need for the year 2 years prior to the rate year and their patient service revenues for the year 2 years prior to the rate year.

(iii) The scale utilized for development of each hospital's nominal payment amount shall be as follows:

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the revenue associated with referred ambulatory patients. The charges shall be collected for the entire year, reduced to cost, and compared to the amount of bad debt and charity care distributions received by the hospital for such services. This data shall be collected on forms and in a manner prescribed by the commissioner of health.

(h) For rate periods commencing January 1, 1997 [and thereafter] through December 31, 2002, \$36 million and for the period January 1, 2003 through June 30, 2003, \$18 million shall be distributed as high need adjustments to general hospitals, excluding major public general hospitals, with nominal payment amount in excess of 4 percent of reported costs as follows: each general hospital's share shall be based on such hospital's aggregate share of nominal payment amount above 4 percent of reported costs compared to the total aggregate nominal payment amount above 4 percent of reported costs of all eligible hospitals.

(i) For rate periods commencing January 1, 1997 and thereafter, distributions to general hospitals described in subdivisions (d) (2) and (h) of this section shall be adjusted as follows:

(1) For general hospitals which qualified for distributions pursuant to section 86-1.66 of this Subpart as of December 31, 1995:

(i) For the rate period commencing January 1, 1997 and ending December 31, 1997, each such general hospital shall receive as an allocation 100 percent of the projected distribution to such general hospital pursuant to paragraph (4) of subdivision (d) of this section for 1996.

(ii) For the rate period commencing January 1, 1998 and ending December 31, 1998, each such general hospital shall receive as an allocation 75 percent of the amount determined in accordance with subparagraph (i) of this paragraph and 25 percent of the amount determined in accordance with subdivision (h) of this section.

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(iii) For the rate period commencing January 1, 1999 and ending December 31, 1999, each such general hospital shall receive as an allocation 50 percent of the amount determined in accordance with subparagraph (i) of this paragraph and 50 percent of the amount determined in accordance with subdivision (h) of this section[.]; and

(iv) For the rate period commencing January 1, 2000 and ending December 31, 2000, each such general hospital shall receive as an allocation 25 percent of the amount determined in accordance with subparagraph (i) of this paragraph and 75 percent of the amount determined in accordance with subdivision (h) of this section; provided, however, that for any general hospital which distribution is greater when determined solely in accordance with subdivision (h) of this section than when determined according to this subparagraph, such general hospital's distribution shall not be adjusted pursuant to this subparagraph; and

(v) for periods on and after January 1, 2001, each such general hospital shall receive as an allocation 100% of the amount determined in accordance with subdivision (h) of this section.

(2) For all other general hospitals, excluding major public general hospitals, general hospitals qualifying for an adjustment pursuant to paragraph (1) of this subdivision, general hospitals which qualified for an adjustment pursuant to section 86-1.84 of this Subpart and rural general hospitals that met the qualifications as a rural general hospital pursuant to clause (e) of section 86-1.52

(a)(1)(iv) of this Subpart in 1996:

(i) For the rate period commencing January 1, 1997

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and ending December 31, 1997, each such general hospital shall receive as an allocation 50 percent of the projected distribution to such general hospital pursuant to subdivision (d)(2) for 1996 and 50 percent of the amount determined in accordance with subdivisions (d)(2) and (h) of this section for rate periods commencing on and after January 1, 1997.

(ii) For the rate period commencing January 1, 1998 and ending December 31, 1998, each such general hospital shall receive as an allocation 25 percent of the projected distribution to such general hospital pursuant to subdivision (d)(2) for 1996 and 75 percent of the amount determined in accordance with subdivisions (d)(2) and (h) of this section for rate periods commencing on and after January 1, 1997.

(j) For rate periods commencing on and after January 1, 1997, distributions to the following categories of hospitals, general hospitals which qualified for distributions pursuant to section 86-1.84 of this Subpart for 1996, rural general hospitals that met the qualifications as a rural general hospital pursuant to clause (e) of section 86-1.52(a)(1)(iv) of this Subpart for 1996, and all other general hospitals, excluding major public general hospitals and general hospitals that

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qualified for distributions pursuant to section 86-1.66 of this Subpart, shall be adjusted as follows:

[(1)] (i) For each category specified in this subdivision, 50 percent of the amount by which the allocation calculated pursuant to subdivisions (d)(2), (h) and (i) of this section for rate periods commencing on and after January 1, 1997 exceeds the projected distribution calculated pursuant to subdivision (d)(2) of this section for 1996 and, if applicable, section 86-1.84 of this Subpart for 1996 shall be reserved by the Commissioner for allocation to general hospitals within such category that would experience a loss based on each such general hospital's proportionate share of the aggregate losses for all general hospitals within such category, provided however, that the amount reserved within a category shall not exceed the aggregate amount of losses within such category.

(k) Supplemental indigent care distributions. From funds in the pool for each year, \$27 million shall be reserved on an annual basis for the periods January 1, 2000 through December 31, 2002 and \$13.5 million shall be reserved for the period January 1, 2003 through June 30, 2003 to be distributed to each hospital on a proportionate share basis, provided that no hospital shall receive less than the graduate medical education reduction amount calculated pursuant to State law, subject to hospital specific disproportionate share payment limits calculated in accordance with section 86-1.87 of this Subpart.

(l) High Need Indigent Care Adjustment Pool. Funds allocated pursuant to State law shall be deposited as authorized and used for the purpose of making Medicaid disproportionate share payments within the limits established on an annualized basis pursuant to section 86-1.87 of this Subpart, for the period January 1, 2000 through June 30, 2003, in accordance with the following:

(1) From the funds in the pool each year: (i) Each eligible rural hospital shall receive \$140,000 on an annualized basis for the periods January 1, 2000 through December 31, 2002 and \$70,000 for the period January 1, 2003 through June 30, 2003, provided as a disproportionate share payment; provided, however, that if such payment pursuant to this subparagraph exceeds a hospital's applicable disproportionate share limit, then the total amount in

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excess of such limit shall be provided as a nondisproportionate share payment in the form of a grant directly from this pool;

(ii) Each such hospital shall also receive an amount calculated by multiplying the facility's uncompensated care need by the appropriate percentage from the following scale based on hospital rankings developed in accordance with each eligible rural hospital's weight as defined by this section:

<u>Rank</u>	<u>Percentage Coverage of Uncompensated Care Need</u>
<u>1-9</u>	<u>60.0%</u>
<u>10-17</u>	<u>52.5%</u>
<u>18-25</u>	<u>45.0%</u>
<u>26-33</u>	<u>37.5%</u>
<u>34-41</u>	<u>30.0%</u>
<u>42-49</u>	<u>22.5%</u>
<u>50-57</u>	<u>15.0%</u>
<u>58+</u>	<u>7.5%</u>

(iii) "Eligible rural hospital", as used in this subdivision, shall mean a general hospital classified as a rural hospital for purposes of determining payment for inpatient services provided beneficiaries of title XVIII of the federal social security act (Medicare) or under state regulations, or a general hospital with a service area which has an average population of less than 175 persons per square mile. The average population of the service area is calculated by multiplying annual patient discharges by the population density per square mile of the county of origin for each patient discharge and dividing by total discharges. Annual patient discharges shall be determined using discharge data for the 1997 rate year, as reported to the commissioner by October 1, 1998. Population density shall be determined utilizing United States census bureau data for 1997.

(iv) "Eligible rural hospital weight", as used in this subdivision, shall mean the result of adding, for each eligible rural hospital:

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(a) The eligible rural hospital's targeted need, as defined in paragraph (5) of subdivision (b) of this section, minus the mean targeted need for all eligible rural hospitals, divided by the standard deviation of the targeted need of all eligible rural hospitals; and

(b) The mean number of beds of all eligible rural hospitals minus the number of beds for an individual hospital, divided by the standard deviation of the number of beds for all eligible rural hospitals.

(2) From the funds in the pool each year, \$36 million on an annualized basis for the periods January 1, 2000 through December 31, 2002 and \$18 million for the period January 1, 2003 through June 30, 2003, of the funds not distributed in accordance with paragraph (1) of this subdivision, shall be distributed in accordance with the formula set forth in subdivision (h) of this section.

(3) From the funds in the pool each year, any funds not distributed in accordance with paragraphs (1) or (2) of this subdivision, shall be distributed in accordance with the formula set forth in subdivision (d) of this section.

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(iii) A bad debt and charity care allowance, a health care services allowance and a financially distressed allowance as determined pursuant to the provisions of section 86-1.65 of this Subpart.

(d) Rates of Payment for Acute Care Children's Hospitals. Hospital services provided to non-Medicare patients in acute care children's hospitals shall be reimbursed on a diagnosis-related group basis composed of:

(1) 1994 reimbursable operating costs computed on the basis of the hospital's reimbursable operating costs as defined in paragraph (a)(4) of this section and statistical data for the same period. The base year Medicare share of these costs will be removed in accordance with paragraph (a)(5) of this section. The non-Medicare hospital operating costs shall be trended to the rate year pursuant to section 86-1.58 of this Subpart and further adjusted for changes in volume and case mix from the base to the rate year using total reimbursable non-Medicare costs and statistics of the hospital pursuant to section 86-1.64 of this Subpart. The DRG specific operating cost component shall be computed utilizing one-hundred percent hospital specific reimbursable costs with no adjustment for long stay or high cost outliers pursuant to section 86-1.54(f)(1) and (3) of this Subpart.

(2) The acute cost component computed on the basis of budgeted capital costs allocated to the inpatient portion of the hospital pursuant to the provisions of section 86-1.59 of this Subpart, divided by the budgeted discharges and shall be reconciled to total actual expenses and discharges;

(4) A health care services allowance of .614 percent for rate year 1994 and .637 percent for rate year 1995 of the hospitals' non-Medicare reimbursement inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(5) Discrete long stay and high cost outlier rates of payment shall not be paid.

(6) For rates of payment for the period April 1, 1996 through July 31, 1996, the operating cost component of rates of payment, excluding any operating cost components related to direct and indirect expenses of graduate medical education for Acute Care Children's Hospitals as determined pursuant to this paragraph shall be reduced by 5%, for the period August 1, 1996 through March 31, 1997 shall be reduced by 2.5% and for the period April 1, 1997 through March 31, 1999 and July 1, 1999 through March 31, [2000] 2003, the operating cost component of rates of payment, excluding any operating cost components related to direct and indirect expenses of graduate medical education, shall be reduced by 3.33% to encourage improved productivity and efficiency.

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Revised Dec 6 JUN 06 2001  
Revised Dec 6 JAN 01 2000

conduct a demonstration to address several patient care related issues including:

- a) the efficacy of utilizing a Short Stay Observation Unit;
- b) the cost-savings of utilizing a Short Stay Observation Unit; and
- c) patient satisfaction, i.e., more comfortable surroundings and a streamlined pathway for evaluation.

Effective January 1, 2000, the Department will conduct a pilot reimbursement project to study the safety and efficacy of the Neuro Cybernetic Prosthesis (NCP) in the State's Medicaid population. The project will provide Medicaid payment for costs associated with implantation of the NCP, also known as the Vagus Nerve Stimulator, on a demonstration basis for two years beginning on January 1, 2000. This device is to be used as an adjunctive therapy in reducing the frequency of seizures for patients with partial onset seizures, which are not responsive to anti-epileptic medications. The project may be conducted at five hospitals across the state. The five facilities must have experience with the implantation of this device and be willing to share data, which will enable the Department to complete its study. The hospitals will be chosen based upon this experience and a recommendation by the Epilepsy Foundation.

TN **00-06** Approval Date **JUN 06 2001**  
Supersedes TN **99-06** Effective Date **JAN 01 2000**